Montana Caregiving Session 2

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A program of the **National Hospice and Palliative Care Organization**

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What is Advance Care Planning?

- Advance care planning is a process, not an event, and is planning for future care based on a person's values, beliefs, preferences, and specific medical issues.
- The future always changes and with it plans for future care. This is not a 'one and done'.
- Far and away the most important aspect of advance care planning is the thought and conversations surrounding it.
- An advance directive is a record of that process and an umbrella term for a document that contains both a record of wishes for treatment (or not) (aka living will) and the appointment of a healthcare agent (aka healthcare power of attorney).
- A POLST is a medical order, signed by a healthcare provider that specifically lists treatments wanted and not wanted.
- Both AD's and POLST's only come into play when a person cannot speak for themselves. The patient ALWAYS will be in charge when they can speak for themselves.

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How Advance Care Planning Changes Over Time

- **You are healthy:** You want to complete an advance directive so, if something suddenly happens and you can't speak for yourself, others will know what you want in general terms. If nothing else, COVID has taught us that unexpected things happen.
- **You have a chronic condition:** You also want to complete an advance directive. Because you know about your disease and its course, you can be more specific in saying what you do and don't want.
- **You have a serious illness:** You also want to complete an advance directive. Because you know about your disease and its course, you can be more specific in saying what you do and don't want. Depending on the predicted course, you may also want to complete a POLST.
- **You know you don't have long:** An advance directive may be useful as it contains more information and nuance than the POLST, but you definitely want a POLST, which is signed by a physician and specifies what treatments you want and don't want at the end of life.

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What is An Advance Directive?

An advance directive is a record of advance care planning and an umbrella term for a document that contains both a record of wishes for treatment (or not) (aka living will) and the appointment of a healthcare agent (aka healthcare power of attorney).

The appointment of the healthcare agent is a legal document that confers certain authority to the agent. This may be done independently of filling out a living will.

The living will portion is a statement of preferences; while a legal document it is not a medical order; it may be overridden in certain circumstances by a healthcare provider; it has no standing outside of a healthcare system (meaning for EMS). The provider cannot just ignore the directive, they must inform you if they are not going to follow it, otherwise there is cause for action.

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What is a POLST?

- A POLST is a portable medical order; it does NOT appoint a healthcare agent.
- A POLST form consists of a set of medical orders that applies to a limited population of patients, such as seriously ill or frail persons, and addresses a limited number of critical medical decisions. A POLST has the option of specifying Do Not Resuscitate (DNR) but also makes provision for other types of treatment such as feeding tubes and mechanical ventilation.
- Because a POLST is a medical order it is filled out in consultation with the healthcare provider. In MT, POLST's may be signed by a physician, a PA (physician's assistant) , or an APRN (advanced practice registered nurse).
- It is possible to download the form and fill it out, but it will not be valid until signed by the medical professional
- It is generally becomes part of your healthcare record.
- POLST orders will be followed by EMS, so long as they are presented.

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How Useful Is An Advance Directive or POLST?

- An AD or POLST is only as useful as its availability at the time it is needed.
- MT has a great registry—doctors and others may need to reminded to access the documents stored there.
- A video clip of what you want and don't want is more useful than an executed document in a safety deposit box.
- Things change—diseases progress, life situations change. It is impossible to predict exact circumstances when the AD or POLST will be consulted.
- If nothing else is done, APPOINT A HEALTHCARE AGENT (HCPOA), and talk with them, then someone will be authorized to speak for you if you can't.

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How Do You Know What Kind of Treatments You Want or Don't Want?

- If you have a specific disease or condition, learn as much as you can about it. Speak with your doctor and other healthcare providers, consult trustworthy websites such as WebMD and MayoClinic or the website of your own institution. The more you know, the better you will understand what treatments are likely, their benefits and risks, and how they fit into your values and view of life. Most of us don't really know what resuscitation for example looks and feels like. There are resources available to explain these and other terms to you:
- The Coalition for Compassionate Care of California has developed videos and decision aids in English, Spanish, Chinese and Vietnamese describing various treatments (scroll to the thumbnails at the bottom of the page).
- Fair Health Consumer offers decision aids as well as information on costs of care.

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What happens if you do not have an Advance Directive in Montana and are unable to speak for yourself?

- The healthcare provider is to notify “interested persons.”
- “Interested persons” who are informed of the patient’s incapacity are to make reasonable efforts to reach consensus. A proxy decision-maker should be someone with a close relationship and “likely to be currently informed of the patient’s wishes regarding medical treatment decisions.”
- Interested persons are a spouse, parent, adult child, sibling or grandchild, or close friend.
- if a healthcare provider cannot, after reasonable efforts, locate a person with authority to make medical decisions or to serve as a lay decisionmaker, the healthcare provider can designate a medical proxy decisionmaker.
- *MT Code §§50-5-1302 and 1303*

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An AD is not a medical order

Healthcare providers are held to a reasonably strict duty to follow AD's if the patient becomes incapacitated but if the following are present, the AD may not be followed.

- The directive sets forth decisions that go against the conscience of the doctor or individual medical services provider,
- The directive sets a policy that goes against the policies of the hospital or other medical institution based on reasons of conscience, or
- The directive includes decisions that would result in ineffective healthcare or asks healthcare providers to adopt healthcare standards that violate those of the provider, hospital or other medical institution.

The provider does have to notify the patient or their agent so that alternatives may be pursued

53% of Medicare patients are treated by Catholic healthcare systems in MT. 60% of rural hospitals are part of Catholic healthcare systems. www.chusa.org

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Other Advance Directive Facts

The Patient Self-Determination Act (1990) requires all healthcare agencies (hospitals, long-term care facilities, and home health agencies) receiving Medicare and Medicaid reimbursement to ask whether you have an advance directive.

There are disease-specific AD's

Psychiatric:

https://nrc-pad.org/

https://nrc-pad.org/states/montana-faq/

https://nrc-pad.org/images/stories/PDFs/montana_hcpaform.pdf

Dementia:

https://dementia-directive.org/

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Montana’s End-of-Life Registry

The Montana End-of-Life Registry is your state’s advance directive registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://www.endoflife.mt.gov .

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Questions?

- https://www.caregiver.org/resource/caregiver-statistics-demographics/

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Thanks!

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